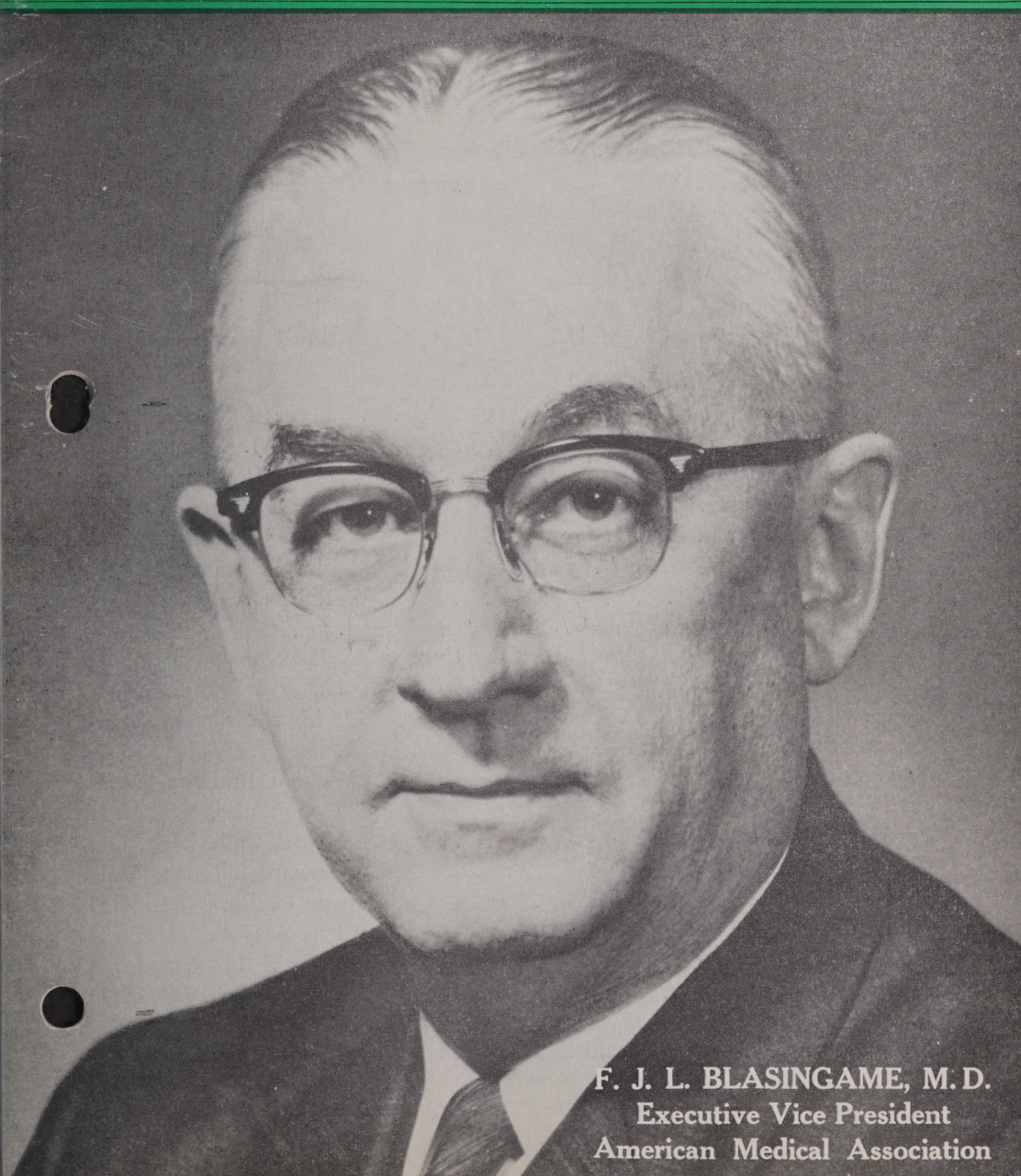
The Hampden Hippocrat

MEMBER MEDICAL SOCIETY MAGAZINE GROUP

A Bulletin for the Hampden District of the Massachusetts Medical Society

VOLUME XXII NOVEMBER, 1966 NO. 9



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American Medical Association

Hampden District Medical Society

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Telephone: 736-0661

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The Hampden Hippocrat

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EDITORIAL

MASS MEDICAID AND YOU

The Medicaid program for Massachusetts (Title XIX) has just been approved by H.E.W., and will soon be in operation. We warmly welcome the approval of this program for our state, a program that is in essence a liberalization of the Kerr-Mills Law, which has had the support of organized medicine from the time it was first proposed. As physicians we have always felt that all persons are entitled to good medical care regardless of finances, and to this end we have always given our services without charge to hospital ward services, out-patient departments, clinics, etc. However, we also recognize the fact that many individuals who are financially secure while in good health, (and, therefore, well above public assistance levels), may require help when a catastrophic illness strikes. We have been seeking solutions to this problem for many years. As a stepping stone to meeting this problem, we have supported the Kerr-Mills Law which, while financed in part by federal funds, was to be locally administered, permitted free choice of physicians, and preserved to a large degree the traditional physician-patient relationship.

NEXT DISTRICT MEETING, DECEMBER 6 (See Page 9)

The Medicaid program deserves our support in that it follows the basic philosophy of the Kerr-Mills Law. However, there are aspects of this program which are of concern to us. We have insisted that there should be a free choice of physicians, and it appears that there will be but only within limits. The level of medical indigency established in Massachusetts is far more realistic than in some other states. While in Massachusetts a family of four will be eligible if the income is under $4,176, in New York the same family may earn up to $6,000 after taxes and still be eligible. These generous limits have so alarmed even the strongest proponents of the program that a Congressional House Ways and Means Committee voted to restrict Title XIX aid by disqualifying some adults from benefits. If Congress approves these new restrictions, New York can still determine whom it will cover, but the federal government will provide matching funds only for those meeting the new qualifications. A Committee spokesman indicated that the new restrictions would also prevent federal funds from going to able bodied people who could work and pay for health insurance.

While the income limits in Massachusetts are far more realistic, and more in keeping with the intent of the law, we must remember that in the determination of net income, state and federal taxes are deducted from gross income. Also deducted are such employment expenses as expense accounts, uniforms, work clothes, union dues, education expenses, and health expenses. Furthermore, there is an exemption of $50 per month on the income of a dependent child under 21 years of age who is working. Therefore it has been estimated that the family of four referred to above may have a gross income of $4500, and the net income may be $4044, well under the $4176 limit in the Massachusetts' program.

Fee Schedules

To care for persons in this income level, physicians must accept as payment in full the fee set forth in the Blue Shield Plan A fee schedule. The fees allowed for office visits are to be $5, for home calls $7, and for night calls $10. For nursing home visits, the fee for the first visit is $7, and $5 for each additional patient. These fees were set up by unilateral action of the Department of Public Welfare; the Massachusetts Medical Society has never accepted the Welfare Department's decision.

Most objectionable is the Plan A Blue Shield schedule. It must be remembered that this fee schedule was well below prevailing fees when it was first set up a quarter century ago. It was intended at that time to help low income families who wished to pay their own way instead of leaning on public welfare or ward services. For these many years, Plan A has been obsolete and all but forgotten. In fact, even the plan B schedule is about 20% below the usual and customary fees, and represents a subsidized fee that is in need of up-dating. It appears then that we are to be penalized for having

attempted to help the low income family 25 years ago with a low Plan A schedule by having the government impose this schedule upon us in 1966 on a take it or leave it basis.

While Medicare is to use customary prevailing fees, Medicaid is to use a fixed low fee schedule. While Medicare may use good semi-private accommodations, Medicaid will use minimum ward accommodations. Free choice of physicians then becomes limited to those physicians accepting the low fees of the Welfare Department. How long will the government allow these two systems to operate differently side by side? How long will it be before the government will place all fees on Medicaid basis? The next step may well be changing the eligibility requirements so that more and more people will come under "free" government care.

The Welfare Department, without consulting us, is attempting to impose a fee schedule upon us which is well below prevailing fees. While physicians have always accepted low fees or no fees at all from low income families, there is no reason to subsidize in similar fashion a government agency which offers medical care with tax monies to large groups of people.

In short, the standards of medical care for Medicaid patients must be the same as for those on Medicare. It is unfair to have two standards of medical care. Accordingly, the Council of the Massachusetts Medical Society has voted that "payments for Welfare patients under Title XIX should be the same reasonable fees as those provided by Title VIII". To this we say, Amen. H.B.T.

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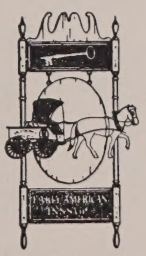

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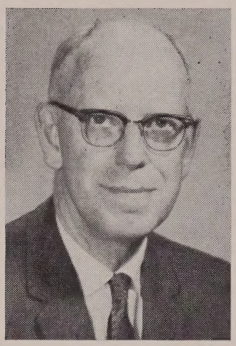
President's Page



OUR AMA

The guest speaker at our next meeting is to be Dr. F. J. L. Blasingame, the Executive Vice-President of the AMA. Hampden District Medical Society is indeed fortunate to have such a busy and illustrious representative of American medicine visit with us. It would seem reasonable to remind the membership at this time of a few facts about our national organization.

The AMA is a federation of state and territorial societies including in its membership about 90% of the eligible physicians in America. Its House of Delegates is constituted on a representative basis - currently, one delegate for each 1000 members, or fraction thereof, of the state society who are also AMA members. Massachusetts has six delegates at present on the basis of 5,047 members of the AMA. This could and should be increased so that we can have seven or eight delegates. If all eligible physicians in Massachusetts were AMA members, we would have 10 delegates and our voice would be that much stronger. Let me urge those of you who are not AMA members to join at once.

If there should be the slightest doubt in anyone's mind as to the scope of the activities of the AMA, take a few minutes to scan the J.A.M.A. of Oct. 24th and note the reports of the committees and councils therein. Think of the man hours involved and the importance of the work being done!

Better yet - come to the December meeting and hear from Dr. Blasingame in person.

DONALD R. HAYES, M.D.

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EXECUTIVE COMMITTEE MEETING
(Highlights)

The Executive Committee met on October 18, 1966, at the Society's meeting rooms. Present were: Drs. Baker, Griffin, Stoler, O'Malley, Moore,, Bloom, Beauchamp, Jr., Burkhardt, Mozden, and Mrs. Purdy. In the absence of Dr. Hayes, President, Dr. Joseph Baker presided. The meeting was called to order at 8:05 P.M.

The minutes of the September meeting were read and approved as read.

Correspondence

A letter from Dr. Eugene Snyder of Chicopee Falls was read as informational. Dr. Snyder is retiring to Florida and is leaving some interesting letters to the Society for its archives.

A letter from Mr. O'Callaghan of the West Springfield Lions Club was read about Glaucoma Clinics to be held on October 15 and 16. Since the clinics were already held, no action was taken.

Two letters from Dr. Susat were read.

In one Dr. Susat reported on his attendance at the public hearing held by the Mass. Dept. of Public Welfare on Sept. 29 in Boston relative to proposed rules and regulations implementing the Medicaid (Title XIX) program in Mass. Most of the discussion revolved around payment for physician services. In spite of many strong arguments by various physicians, it seemed "cut and dry" insofar as the Dept. was concerned that the Plan A Blue Shield, Schedule was going to be followed. It was even implied that this fee schedule was negotiated and agreed upon by the MMS. This was emphatically denied by Dr. Broderick, Chairman of the MMS Committee on Tax Supported Medical Care. Specifically, Dr. Susat was greatly concerned with Rule 3 of the "Rules for the Administration of the Medical Assistance Program" wherein the following sentence appears: "Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee schedule." Although not specifically brought out, Dr. Susat seemed to feel that each physician might be required to enter into some written agreement with the Dept. in order to participate in the program. It is Dr. Susat's intention not only to alert the Society and its membership to this possibility but also to solicit careful consideration for a positive stand in the eventuality.

The second letter from Dr. Susat dealt with the question he had asked Dr. Parker at the Sept. 27th meeting of the Society pertaining to the articles of agreement which physicians must sign to participate in C.M.P.A. Specifically, in the "Agreement," Article 8, Paragraph B states: *"Payment shall first be made . . . in an amount up to* 80% *of the reasonable charges."* Yet, all the pronouncements emanating from the literature and spokesmen of the MMS Committee on

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Physicians' Payments under Medicare set a flat minimum of 80% initial reimbursement to a physician participating in C.M.P.A. with the remaining 20% to be partially reimbursed at a later date. Following this matter up, Dr. Susat has definitely ascertained from the aforementioned Committee that Article 8, Paragraph B of the "Agreement" does *permit an initial payment in an amount less than* 80% *of the charges.* However, the Committee contends that this same Article 8, Paragraph B, in no way relieves the fund of the obligation ultimately to reimburse the participating physician for the full amount of his fees, subject to reduction only by the amounts of his pro rata share of operating costs and bad debts.

It is Dr. Susat's contention that the Committee has made misrepresentations in promoting participation in C.M.P.A.; hence, investigation by and explanation to the Society are in order before any more members sign the "Agreement."

Committee Reports

Three scholarships have been awarded to a nursing student and two medical students. (See page 26)

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The Medico-Legal Committee will hold a joint dinner meeting of the Hampden Bar Association and the HDMS on March 7, 1967 at the Shaker Farms Country Club with a speaker from the Law Department of the AMA.

The Public Health Committee is sponsoring a "Sports Injury Program" on November 30, 1967 at 2:00 P.M. in the Municipal Hospital Auditorium. (See page 23)

The Diabetes Detection program is progressing well with publicity well underway. This program is being run in cooperation with the Springfield Health Department and the Springfield Druggist Association.

Dr. Moore gave the Treasurer's report. Fifteen members have as yet to pay this year's dues. Only 92 copies of the "Relative Value Study" have been sold.

Dr. John Turner was appointed by Dr. Hayes to fill the vacancy on the MMS Council as brought about by Dr. Miller's resignation. The Committee approved this appointment.

The business meeting was adjourned at 8:40 P.M.

The Grievance Committee convened and heard one case.

The meeting was adjourned at 9 P.M.

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—Horace Greeley

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F. J. L. BLASINGAME, M.D.
EXECUTIVE VICE PRESIDENT
A. M. A.

F. J. L. Blasingame, M.D., while born in Arkansas some 58 years ago, has spent most of his life in Texas. He received his training at the University of Texas in Austin and Galveston graduating therefrom in 1932 and interning at the Henry Ford Hospital in Detroit, Michigan. Before entering into private practice in Wharton, Texas, he was a full-time teacher of anatomy in the Medical Branch of the University of Texas for four years and maintained this teaching affiliation until 1958 when he became Executive Vice President of the A.M.A.

Prior to his A.M.A. appointment, Dr. Blasingame had been active in medical affairs at both the state and national level for many years. When the A.M.A. House of Delegates elected him a member of the Board of Trustees in 1949, he was one of the youngest physicians ever chosen. From that time on he held many important A.M.A. committee appointments. He also served as President of the Texas State Medical Association in 1955.

Dr. Blasingame had been active in civic affairs for many years not only in his home town but throughout Texas. He was at one time President of the Blue Cross-Blue Shield Plans of Texas, Chairman of the Board of Trustees of Wharton County Junior College, and Chairman of the Medical Advisory Board of Sears, Roebuck Foundation.

Over the years, Dr. Blasingame has manifested all the essentials of leadership, plus knowledge, imagination, and sound thinking. His work on behalf of medicine has shown that he has courage and initiative to shoulder responsibility.

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NEXT MEETING

OF THE

HAMPDEN DISTRICT MEDICAL SOCIETY

TIME: **TUESDAY, DECEMBER 6, 1966**

Business Meeting 6:30 P.M., followed by

Social Hour at 7:00 P.M. and

Dinner (Courtesy of Society)

at 7:30 P.M.

PLACE: **KIMBALL TOWERS**

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GUEST SPEAKER: **F. J. L. BLASINGAME, M.D.**

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MMS COUNCIL MEETING HIGHLIGHTS

A stated meeting of the Council of the MMS was held at the Hotel Somerset, Boston, on October 19, 1966. The meeting was called to order by President Babson at 10:30 A.M.

The Council stood for a moment of silence in memory of our own Dr. George L. Schadt, former President of the HDMS and of the MMS.

Dr. Edward O. Broderick, Chairman of the Committee on Tax Suported Medical Care, introduced two resolutions:

(1) Payments for welfare patients and others who will come under Title XIX should be the same as those provided by XVIII and,

(2) The same carrier be used to administer Title XIX as is now responsible for Title XVIII.

Both resolutions were approved.

Dr. Broderick also announced that Medicaid has been approved for Massachusetts and that Plan A, Blue Shield, fee schedule will be used.

Dr. Claude E. Welch, Chairman of the Committee on Title XIX introduced several resolutions for considerations of the Council:

(1) There should be a free choice of physicians by the patients (this free choice does not exist in the New York Plan).

(2) Payments for welfare patients under Title XIX should be the same reasonable fees as those provided by Title XVIII. These two resolutions were approved. A third resolution was withdrawn and replaced with a similar proposal suggested by Dr. Fiumara, recommending a study of the organization of state and local welfare departments for the purpose of the establishment of uniform policies and procedures throughout the Commonwealth. This resolution was approved. A fourth resolution recommending that there be a realistic level established for medical indigency was also approved. Finally the Committee recommended that it serve either collectively or individually, upon the request of the Governor, as an Advisory Committee of the MMS on Title XIX to the Department of Public Welfare. This was approved by the Council.

Following a fine luncheon of baked fish, the meeting was resumed at 1:30 P.M.

The first item for consideration was a joint resolution of the Massachusetts Chapter of the American College of Surgeons and The Massachusetts Chapter of the American Academy of General Practice. This resolution was submitted at the Council meeting of May 16, 1966, and had been referred to the Executive Committee for consideration.

More on Page 14

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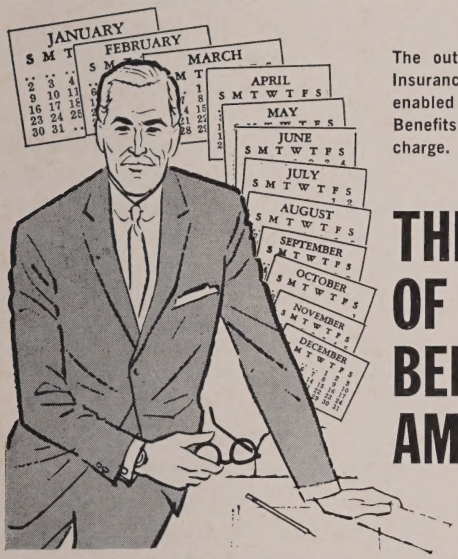

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The extension of benefits as described in the following letter from Lester L. Burdick, Inc. was approved by the Committee on Members' Insurance Programs and reported to the Council of the Massachusetts Medical Society:

"In accordance with the committee's suggestion, we are agreeable to increase the benefit period under Section A from 260 (5 years) to 312 weeks (6 years). This represents 52 additional weeks.

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This resolution approves a Council resolution of February 12, 1964 but recommends certain significant changes.

Because of some discrepancies in the joint resolutions, it was voted to refer it back to the Executive Committee for further consideration and clarification.

Following the suspension of rules, two resolutions dealing with Medicaid were considered.

Resolution 1. Since Blue Shield Service contracts were initiated by the medical profession to help underwrite and subsidize the medical expenses of low-income families,

and since these expenses are now to be underwritten entirely by the government,

and since it is morally indefensible for Blue Cross-Blue Shield to accept money from these people for medical and hospital care being granted free by the government,

Therefore, be it resolved that the Middlesex East District Medical Society instruct its councilors to call for the immediate cessation of collection of Blue Cross-Blue Shield premiums for all people qualifying for Medicaid.

Resolution 2. Since the reason for Service Benefits was to provide medical care at low cost to the medically indigent,

and since government now is to provide funds for the care of all who are medically indigent,

and since those who do not qualify for Medicaid are not medically indigent,

Therefore, be it resolved that the Service Benefit concept be eliminated from all Blue Shield contracts covering those who do not qualify for Medicaid and, therefore are not medically indigent.

Resolution #1 was referred to the committee. The same fate befell Resolution #2.

Next was yet another resolution by Middlesex East. This one recommended that the MMS urge Blue Shield to apply as soon as possible to the Insurance Commissioner for a change in the fee schedule to bring it into a closer relationship with the level of prevailing fees. This was approved.

A resolution by Dr. Burden that a section on Orthopedic Surgery be established in the MMS was approved.

Approved also was a resolution from Charles River which recommneds that

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Blue Cross rules be revised to permit payment by Blue Shield for services by Blue Cross or by or through a hospital.

A resolution that the deans of the Massachusetts' medical schools be made ex-officio councilors of the MMS was referred to committee.

The informational reports of the committees on Legislation, Medical Education, Professional Liability, Hospital and Professional Relations, and on Members Insurance Programs were received by the Council.

Resolution #1 of The Medical Charges Review Committee as reported by its chairman, Dr. Allen S. Johnson (Hampden) was approved with minor modifications. It now reads: "That the income and financial status of individuals with medical expense insurance shall not be considered in determining the amount of reasonable charges for which an insurance company is liable."

Resolution #2 was approved as originally published in The Circular of Advance Information (Page 18). It reads: "That the following factors shall continue to be considered in determining the reasonableness of a fee:

A. The character and amount of the service.
B. The usual fee charged by other doctors in the same area for the same service.
C. The particular skills of the doctor performing the services."

The meeting was characterized by an unusual number of new resolutions, most of which were either tabled or referred to committee.

The meeting adjourned at 5:30 P.M.

Notwithstanding a steady downpour no fewer than seventeen Hampdenites were in attendance.

Tillman

COUNCIL ATTENDANCE

The following members were in attendance at the meeting of the Council of the Massachusetts Medical Society on October 19, 1966: Drs. J. J. Arenstam, J. C. Ayres, B. Bloom, H. Burkhardt, J. J. Callan, E. F. Franseen, R. S. Johnson, J. R. Kelley, R. N. LaMarche, R. Maher, M. Millman, T. R. Miner, T. F. Reilly, H. N. Simpson, K. J. Susat, and H. B. Tillman.

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—James R. Adams

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SQUIBB NOTES ON THERAPY

"'Tranquilizer' is not a good word"[1]

"This classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories—the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also

under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert.

References: 1. Simpson, G.M.: Postgrad. Med. *39*:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: *65*:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med.: *25*:553, 1961. 7. Sainz, A.: Psychosomatics *5*:167, 1964.

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OUR SEA OF AIR

Through most of our history, we have exploited our natural resources as though we believed them to be inexhaustible. In view of the apparent vastness of the atmosphere, it is not surprising that we have only recently begun to recognize that this resource, too, is limited. Even if it cannot be depleted, it can certainly be perilously contaminated.

The immensity of our air resource is almost beyond our ability to imagine or to picture in terms related to our human experience. To refer to it as "an ocean of air" is almost to belittle it. For it covers every inch of the 200 million square miles of the earth's surface — land and water — to a height of several hundred miles. To calculate its weight in tons, we need a 6 followed by 15 zeros. This would certainly seem at first thought to be far too vast to be significantly depleted, polluted, or otherwise significantly changed by the activities of man.

Our atmosphere extends far above the earth's surface, the upper limit being impossible to define exactly. Somewhere between 250 and 900 miles above the earth, the air gradually merges into empty space, and it becomes ever less dense with increasing height. However, some 95% of the total air mass is concentrated in a comparatively thin layer extending some 12 miles above the earth's crust. Totally, we are rightly endowed with an atmospheric resource of great magnitude, and most of it is located proximate to the earth's surface, where it is of most utility to man and his activities.

Vast But Limited

The portion of our air resource available for the disposal of waste is a very small fraction of the earth's total atmosphere. In spite of daily and seasonal variations, the air supply available to any urban area is basically fixed, and the ability of the atmosphere to dilute and disperse pollutants is limited. At any one location, the amount of air available for dispersing and diluting pollutants depends most of all upon two highly variable factors — the wind speed and the depth in the atmosphere in which mixing of air from near the surface takes place. While the effect of the first factor, wind speed, is obvious, the limitation of the second, atmospheric mixing depth, is not so generally understood.

The mixing depth in the atmosphere is associated with its temperature variation above. For instance, the existence of "temperature inversions" or departures from adiabatic temperature decrease as one proceeds upward from the ground surface. The mixing depth in the atmosphere during daylights hours varies significantly from season to season. During the summer,

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in the United States, it usually extends upward for several thousand feet, being highest over the Rockies and the Appalachian Mountains. During the winter, on the other hand, when there is less heating from the sun, the maximum mixing depth averages only from 700 to 800 feet up to approximately 2500 feet over the entire United States. This inherent limitation on the capacity of the open atmosphere to dilute and disperse pollutants becomes particularly important when coupled with the increasing concentration of our sources of air pollution. The sooner all of us recognize this important fact, the greater will be our chances for keeping air pollution from overwhelming us, for in no other area of resource management do we have so little room for error as we have here.

Effects

If we were to follow the same course with regard to our limited air resources as we have with many other resources in the past, the consequences of such negligence would be intolerable. We can plant trees and grass to restore the land, and we can treat the effluent discharges into streams in order to produce drinking water, but we must breathe the air with its burden of pollution as it too comes to us.

The effects of air pollution are serious now. In economic losses alone, air pollution costs the country billions of dollars a year through injury to vegetation and livestock, corrosion and soiling of materials and structures, depression of property values, and in-

terference with ground and air transportation. Of even greater significance are the adverse effects of air pollution on human health, and here we must be concerned not just with the threat of severe air pollution episodes capable of causing acute illness and death, but also with the hazards of long-continued exposure to the levels of air pollution which are common in many American communities. A growing body of scientific evidence indicates that exposure to ordinary levels of air pollution adversely affects the health of many people and is associated with the occurrence and worsening of chronic respiratory diseases and with premature death of aged and ailing persons. Air pollution has been shown to be related to increased mortality from cardio-respiratory disorders, increased susceptibility to respiratory disease, and interference with normal respiratory function. Specific diseases associated in one degree or another with air pollution are emphysema, chronic bronchitis, asthma, lung cancer, and non-specific respiratory infections, (i.e., the common cold).

Recent Local Program

A development program to control air pollution in the Lower Pioneer Valley began in February 1965.

This program, sponsored jointly by the Massachusetts Department of Public Health and local boards of health, resulted from an air sampling survey of the Springfield area in 1963, which emphasized the need for a more comprehensive approach to air pollution within the area.

An air pollution control engineer was assigned to be in charge of the program and was assisted by a chemist for laboratory and field work. Local and state health departments have assigned other personnel on a part time basis.

The development program was the first step to establish a regional air pollution control program in the Lower Pioneer Valley. To better define the air pollution problem:

(1) a composite sampling network was established;

(2) the laboratory at the West Massachusetts Public Health Center in Amherst was equipped for the analysis of air contaminants;

(3) a study of potential air contaminant sources is being made;

(4) a study of the effect of meteorological and topographical

More on Page 22

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factors upon air pollution within the area is being studied.

Within the Lower Pioneer Valley, air pollution generally arises from four major factors or contributors: (1) waste disposal, (2) fuel usage, (3) industrial activities, and (4) natural occurrence. Contributing sources can be classified as agricultural, commercial, domestic, industrial, municipal, transportation and natural. Much data has already been gathered, is presently being analyzed, and will be reported on in the very near future.

A Regional Program

Since the dispersion of air contaminants does not respect political boundaries, the control of air pollution can most efficiently be attained by a cooperative regional approach. A regional approach would have the advantages of providing:

(1) supervision of air contaminant sources within the entire area,

(2) uniform air pollution control regulation for the region,

(3) skilled personnel and facilities needed for air pollution control, and

(4) increased financial assistance from the Federal government.

The General Laws of Massachusetts permit the establishment of air pollution control districts under Chapter III, section 142C. The law provides that two or more cities or towns of contiguous territory wishing to form an air pollution district shall make application to the Massachusetts Department of Public Health requesting the Department to approve such a district and to effect the control of air pollution therein. Such an air pollution control district has already been formed and the following local communities have officially committed themselves to becoming a part of the said district: Agawam, Easthampton, East Longmeadow, Chicopee, Holyoke, South Hadley, Springfield, Westfield, and West Springfield. It is hoped that in the near future Longmeadow and Northampton will also be joining the district.

The estimated cost of establishing the air pollution control district is approximately $48,000.00. Included in this cost are the salaries of a senior air pollution engineer, a chemist, 2 air pollution control inspectors, clerical help, and the necessary equipment to operate the program. Costs to the cities and towns for such a program is to be based on the provisions of Chapter III, section 142B, which states *that costs will be apportioned one-half on assessed valuation and one-half on population.* Under the provisions of the Clean Air Act of 1963, Public Law 88-206, the Federal government will provide funds to assist in the establishment of regional air pollution districts in the proportion of 3 to 1. This results in a combined cost to the cities and towns participating in the district of approximately $12,000.00.

Since this problem will become more severe in the future with increasing population and economic growth, a regional program to control air pollution is the most practical method of assuring satisfactory air quality within our area.

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2:00 P.M. to 5:00 P.M.

PLACE: W. A. R. CHAPIN AUDITORIUM
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1400 State Street

PROGRAM:

(1) "LOWER EXTREMITIES"

Mordecai Berkowitz, M.D.
Springfield, Mass.

(2) "MOUTH INJURIES"

Irving Meyer, D.M.D.
Springfield, Mass.

(3) "BACK INJURIES"

Howard Crawford, M.D.
Springfield, Mass.

(4) QUESTIONS and ANSWERS

INVITED: Coaches, trainers, physical education instructors, athletic department heads and their staffs, and all interested persons.

MASS. MEDICAID APPROVED

Massachusetts joins 18 other states in having a Medicaid program approved by the U.S. Department of Health, Education, and Welfare.

As explained in the *Hippocrat* (Sept. 1966), Medicaid, which is Title XIX of the 1965 Amendments to the Social Security Act differs from Medicare (Title XVIII) in that the latter concerns only persons over 65 years of age, and is financed through the Social Security System. On the other hand, Medicaid benefits people of all ages, is totally divorced from the Social Security System, and is financed by matching federal and state funds, the ratio depending on the per capita income of the state concerned. Each state sets up its own program including, eligibility requirements, and if H.E.W. approves the program, federal grants match state funds to place the plan in operation. Standards of medical care are determined by the federal government, but each state determines its own eligibility requirements.

The Mass. plan, just approved, covers all persons receiving aid or assistance under one of the federally aided public assistance programs. In addition, Medicaid benefits will be available to all single persons whose annual net income is under $2,160 or to a family of four whose annual net income does not exceed $4,176.

The services provided include inpatient and out-patient hospital care, physicians services, including specialists and consultants wherever furnished, nursing home care, and laboratory and X-ray services.

Federal funds will cover half the cost of the program, while 2/3's of the remaining half will be paid for by the state, and 1/3 by the cities and towns. The program will be administered by the State Department of Public Welfare except for those who are under the jurisdiction of the State Commission for the Blind.

Welfare commissioner, Robert F. Ott, indicated that a person may be eligible if his monthly net income is less than $180 per month, plus $56 for each additional person covered. The personal property allowance is $2,000 for one person, or $3,000 for two persons, plus $100 for each additional dependent.

Tillman

(For editorial comment on Medicaid, see Page One).

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ACADEMY

The next meeting of the

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will be held on

TUESDAY, DECEMBER 13, 8:30 P.M.

SPEAKER:	JOHN H. BYRNE, M.D. Director, Third Surgical Service, and Research Laboratory Boston City Hospital Boston, Mass.
TOPIC:	"SHOCK"
PLACE:	Auditorium, Municipal Hospital Springfield
HOSPITAL CLINIC:	Providence Hospital, Holyoke, 5:00 P.M.

COMING EVENTS

HDMS MEETING, DECEMBER 6, 1966 **(See Page 9)**

HDMS EXECUTIVE COMMITTEE MEETINGS,
NOVEMBER 15 and DECEMBER 20

DIABETES DETECTION WEEK, NOVEMBER 13-19

HDMS CENSOR MEETING, DECEMBER 1

MMS COUNCIL MEETING, FEBRUARY 8

AMA CLINICAL MEETING, LAS VEGAS, NEV., NOV. 27-30

H D M S
SCHOLARSHIP AWARDS
1966

Dr. B. Lincoln Wales, Jr., Chairman of the Scholarship Committee of the Hampden District Medical Society has announced the recipients of three scholarships given this year.

Miss Judith Lund received an award for the Hartford Hospital School of Nursing. Miss Lund graduated from the Agawam Senior High School in June of 1966 and was a member of the Future Nurses of America for four years. She is the daughter of Mr. and Mrs. Eugene Lund of Elbert Road in Agawam.

Mr. Francis N. Tremblay received an award for the University of Vermont, College of Medicine. Mr. Tremblay graduated from Assumption College in June of 1966 and is in his first year of medical school. He is the son of the late Mr. Eugene G. Tremblay and Mrs. Marie Tremblay of Los Angeles Street, Springfield.

Mr. Paul C. Salmonsen is the third recipient of an award. He attends Baylor University, College of Medicine in Houston, Texas. Mr. Salmonsen graduated from Yale College in 1964. He is the son of Mr. and Mrs. Gordon Salmonsen of Albert Street in Agawam.

Other members of the Scholarship Committee assisting Dr. Wales are Dr. Frederick Hopkins and Dr. Victor Grover.

Many applications were received all of which merited consideration for these awards. The Committee stated that it was unfortunate that more funds are not available. The Hampden District Medical Society makes annual grants each year to residents of Hampden County who are enrolled at any qualified educational institution for the purpose of devoting their lives to service in the fields of nursing, pharmacy or medicine. The money for the funds providing the income for these scholarships has come from all the people of the communities involved. These awards are based primarily on financial need in conjunction with reasonable assurance that the student has sufficient overall competence to complete his or her course of study and to enter the practice of his or her chosen profession with credit to the community, wherever that may be.

Applications for these scholarships are received at the Hampden District Medical Society, 1414 State Street, Springfield at any time during the year up until September 1st of each year.

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HAMPDEN CAPSULES

Radio WACE Speakers:

Nov. 4 — Dr. Lewis Whiting - "Death with Dignity"

Nov. 11 — Dr. Louis Izenstein - Diabetes Detection Week

Nov. 18 — Dr. Roland Stebbins - Sports Injury Program

— —

Dr. Sante Caldarola and Dr. Jacob B. Shammash were recently inducted as new Fellows of the American College of Surgeons in San Francisco.

— —

Dr. Newmark will be on TV with Barbara Bernard, WHYN, Nov. 8 and Dec. 2.

"Keeping Children Healthy"

— —

New Transfers

Dr. Normand S. R. Naumoff transferred from Suffolk District to Hampden and is taking over Dr. Eugene Snyder's practice in Chicopee Falls.

— —

October has been keeping members busy with speaking engagements.

Dr. Zadworny — Glenwood PTA, Oct. 4

Dr. Hill — East Longmeadow Child Study Group, Oct. 19

Dr. Pelletier — Mittineague School, West Springfield, Oct. 11

Dr. Janavoky — Tiffany St. School, Oct. 18

Dr. Hojnoski — Our Lady of the Rosary PTA, Oct. 19

Starting off Community Health Week — Dr. Sears and Dr. Zadworny showed two VD movies at the Springfield Municipal Hospital to 125 teen agers and parents, October 17.

Dr. Walter Carver — Industrial Nurses on Medicare, Oct. 8

Dr. Zadworny — Rainbow Girls in West Springfield, Oct. 27

Mrs. Purdy on Radio WACE with Jack Hurley on his last program before leaving for Louisville, Kentucky for a TV position — conversing about Patient-Doctor Relationship.

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Dr. Donald R. Hayes has been elected to serve on the Board of Governors of the American College of Surgeons.

— —

Dr. Jerome Whitney has been appointed by Governor Volpe to serve as a member of a special commission established to make a study relative to retarded children and the training facilities available therefor.

— —

Committee meetings held during October:
Members Insurance, Malpractice and Medico-Legal Affairs,
Executive, Medico-Religious, Diabetes Detection

— —

To meet during November:
Mental Health, Public Health, Members Insurance,
Executive, Sports Injury Program

VACCINES AVAILABLE

The Mass. Dept. of Public Health has now established at the Springfield Dept. of Public Health a depot supplying both the trivalent Sabin polio vaccine and the live attenuated measles vaccine, Schwarz strain. Both vaccines are available free of charge to physicians for their own patients as well as to local boards of health or health depts. for mass immunization programs.

Physicians should not draw more vaccine than they expect to use in a week's time on their private patients. In the interest of economy, outdated measle vaccine must be returned to the depot since the manufacturer will replace same without cost.

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THE AUXILIARY'S TOUR OF DOCTORS' HOMES

On Wednesday, October 19, 1966, the Woman's Auxiliary to the HDMS sponsored a tour of doctors' homes in the Longmeadow and East Longmeadow area. The event featured residences of interesting and unusual architecture and decor.

Amongst the homes generously and graciously opened for public viewing were those of Dr. and Mrs. Joseph Baker, Dr. and Mrs. Joel Bettigole, Dr. and Mrs. Joseph Hahn, Dr. and Mrs. Aldo Leani, Dr. and Mrs. Sawyer Medbury, Dr. and Mrs. Bernard Tillman, and Dr. and Mrs. Lawrence Seldon.

Under the chairmanship of Mrs. Richard Paul and with the assistance of many Auxiliary members both at headquarters, the Longmeadow Community House, and the various residences, the event proved to be most delightful. Approximately 332 persons availed themselves of this splendid viewing opportunity. Moreover, the AMA Education and Research Foundation, which makes generous contributions to medical schools in the United States and Canada, will benefit by more than $800.00 as a result thereof.

The Auxiliary is most grateful to those who so opened up their homes and to the many members of the Auxiliary who worked so hard to make this affair so successful.

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Perfection is obtained by slow degrees; it requires the hand of time.
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THE SPRINGFIELD HOSPITAL EDUCATIONAL PROGRAM

Arnold P. Gold, M.D., Assistant Attending Neurologist and Pediatrician, Columbia-Presbyterian Medical Center and Assistant Professor of Neurology and Pediatrics, Columbia University, New York, will be featured on the pediatric guest speaker program which will be held on Thursday, Dec. 1, 1966 in the Hospital's Auditorium. There will be a clinical session at 5:00 P.M., pediatric rounds at 6:00 P.M., and a formal presentation entitled "Pediatric Neurologic Diagnosis by Inspection" at 8:00 P.M.

Morris J. Nicholson, M.D., Dept. of Anesthesiology, Lahey Clinic, and Anesthesiologist, New England Deaconess Hospital, and Associate Anestheologist, New England Baptist Hospital,, Boston, Mass., will speak on "Circulatory Emergencies in the Operating Room and Recovery Room" on Friday, November 25, 1966 at 7:30 P.M. in the Hospital's Auditorium.

Louis R. Orkin, M.D., Professor and Chairman, Department of Anesthesia, Albert Einstein College of Medicine, Yesiva University and Director of Anesthesiology, Bronx Municipal Hospital Center, New York, N. Y., will lecture on "Shock and the Surgical Patient" on Friday, December 2, 1966, at 7:30 P.M. in the Hospital's Auditorium.

All physicians, residents, interns, nurses, and military personnel are cordially invited to attend.

We learn to do neither by thinking nor by doing; we learn to do thinking about what we are doing.

—George D. Stoddard

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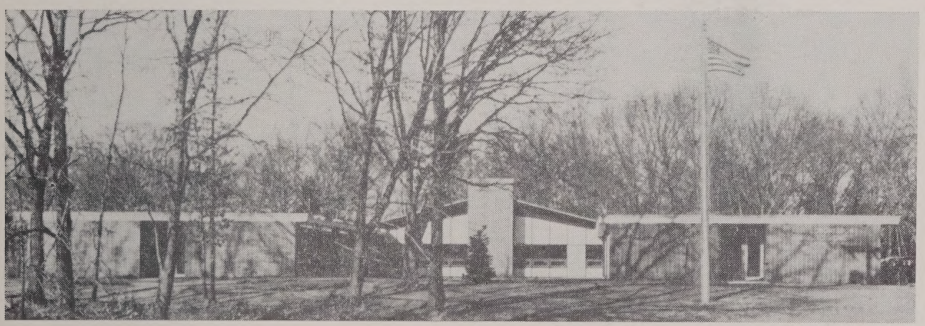

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